Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN ANTONIO SPINE & REHAB
1313 SE MILITARY ROAD SUITE 107
SAN ANTONIO TEXAS 78214

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
UNIVERSITY HEALTH SYSTEM

Carrier's Austin Representative Box
Box Number 16

MFDR Tracking Number
M4-12-0135-01

MFDR Date Received
September 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauth obtained for CPT code AP170898."

Amount in Dispute: $79.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to the Medical Fee Guideline rule 134.2039(b)(1) [sic], reimbursement for professional medical services is based on Medicare policies including correct coding initiatives. The enclosed CMS 1500 indicates in addition to billing code 97140 the provider also billed 98940. The NCCI edits indicates code 97140 is bundled to code 98940 unless modifier 59 was utilized. As evidenced by the enclosed billing modifier 50 was not billed indicating a separate distinct service. Therefore, procedure code 97140 was correctly denied and no additional allowance is due."

Response Submitted by: ARGUS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2011 and February 17, 2011	97140	$79.36	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the medical fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 15, 2011

   - 97A – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Per the National Correct Coding Initiative Edits

   Explanation of benefits dated July 6, 2011

   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 97A – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Per the National Correct Coding Initiative Edits.

Issues

1. Did the requestor bill for CPT codes that are included in the payment of another procedure/service per NCCI edit?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 (b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
2. The requestor disputes denial of CPT code 97140 rendered on February 14, 2011 and February 17, 2011.
3. Review of the CMS-1500 indicates that the requestor billed the following CPT codes on February 14, 2011 and February 17, 2011:
   - 98940, 97110, G0283 and 97140
4. CCI edits were run to determine if edit conflicts exist for the disputed CPT codes. The following edit conflicts were identified.
   - Per CCI Guidelines, Procedure Code 97140 has a CCI conflict with Procedure Code 98940.
5. Therefore, for the reasons noted above, reimbursement cannot be recommended for the disputed CPT code 97140 rendered on February 14, 2011 and February 17, 2011.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.